



National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

LOG M-353

Date: August 8, 1989

In reply refer to: M-89-39 and -40

Honorable Samuel K. Skinner
 Secretary
 U.S. Department of Transportation
 Washington, D.C. 20590

At 1945, on September 2, 1988, the Bahamian tankship ESSO PUERTO RICO departed the Exxon facility in Baton Rouge, Louisiana with a cargo of carbon black feedstock oil bound for Rotterdam, Netherlands. The vessel's downriver transit was without incident until the vessel approached Kenner Bend and the pilot sighted the Philippine bulk carrier LONGEVITY ahead which was at anchor and lying crosswise in the river. The deep water channel was to the stern of the anchored LONGEVITY, but the pilot did not believe that there was sufficient room astern of the LONGEVITY for the ESSO PUERTO RICO to pass safely. Therefore, he piloted the ESSO PUERTO RICO past the bow of the LONGEVITY. In so doing, the vessel left the confines of the deep water channel, entered an area of shallow water, and returned to the deep water channel downstream from the LONGEVITY. Shortly thereafter, the ESSO PUERTO RICO developed a port list which continued to worsen until it reached 8 degrees. The master ordered the cargo tanks sounded, and it was discovered that approximately 6 meters of cargo had been lost from the No. 1 starboard cargo tank. The ESSO PUERTO RICO then proceeded to anchorage. A diver examined the hull and found a 32-foot-long gash in the bottom of the No. 1 starboard cargo tank. The 4,003.6 metric tons of carbon black oil that had been contained in the No. 1 starboard cargo tank leaked into the Mississippi River.¹

The pilot of the ESSO PUERTO RICO stated that he first became aware of the presence of the LONGEVITY when the ESSO PUERTO RICO was in Fairview Crossing. The pilot further stated that in order to have had a minimally sufficient distance in which to have stopped his vessel short of the anchored vessel, he would have had to have known of the LONGEVITY's position in the river by the time the ESSO PUERTO RICO had arrived near mile 118. In the past, such foreknowledge could have been obtained from the New Orleans VTS which routinely received and disseminated reports concerning vessel positions and hazards to navigation. However, the New Orleans VTS had been closed since April 1, 1988. In the absence of the VTS, the pilot could have learned of the presence of the LONGEVITY from the operator of a passing vessel or

¹For more detailed information, read Marine Accident Report--"Striking of a Submerged Object by the Bahamian Tankship ESSO PUERTO RICO, Mississippi River, Kenner, Louisiana, September 3, 1988" (NTSB/MAR-89/02).

from the NOBRA pilot office which had received a report that the LONGEVITY was infringing on the navigable channel. If the NOBRA pilot office, which should have known that one of their pilots was approaching the area, had issued an appropriate warning to the pilots, the pilot of the ESSO PUERTO RICO would have learned of the LONGEVITY's position in time for him to have reduced his vessel's speed sufficiently for him to stop short of the LONGEVITY or to maneuver with caution around the LONGEVITY. However, a safety warning issued only to the NOBRA pilots falls short of providing adequate warning to all mariners who may be affected by such a hazard to navigation. Other mariners who operate vessels in this portion of the Mississippi River, such as Federal pilots and towboat operators, have just as great a need to know about the presence of hazards to navigation as the NOBRA pilots.

The Safety Board believes that this accident clearly demonstrates the value of a VTS in the New Orleans area. If the New Orleans VTS had been operational and if the NOBRA pilot who reported that the LONGEVITY was infringing on the navigable channel had made the same report to the VTS, the VTS personnel would have warned all mariners in the area, including the pilot of the ESSO PUERTO RICO, and this accident may have been avoided. Additionally, the VTS personnel may have been able to contact the LONGEVITY deck watch by radio and informed them that their vessel should be moved. The ship's crew could then have made emergency maneuvers to move the vessel away from the deep water channel, even before a pilot arrived on board, just as they had done previously when they moved their vessel away from the barges moored along the river bank in the first anchorage position.

As a result of an investigation of a recent accident² in New York Harbor, the Safety Board made the following recommendation to the U.S. Department of Transportation (DOT):

M-88-39

Maintain the services currently provided by the New York, New York, and Valdez, Alaska, Vessel Traffic Services (VTS), and not only to reestablish the services originally provided by the New Orleans VTS but also to upgrade the equipment using the allocated funds.

The Safety Board has yet to receive a response to Safety Recommendation M-88-39 from DOT. The Safety Board has, however, received a response to this recommendation from the Commandant of the Coast Guard. In this response, dated September 13, 1988, the Commandant stated:

²Marine Accident Report--"Ramming of the Maltese Bulk Carrier MONT FORT by the British Tankship MAERSK NEPTUNE in Upper New York Bay, February 15, 1988" (NTSB/MAR-88/09).

We agree with NTSB's position, 'The Coast Guard's VTS operations provide valuable safety protection to the traveling public.' No doubt about it, VTS's are a navigation safety enhancement - closing them will have a safety impact. Our FY 1988 budget shortfall was the deciding factor in closing and reducing some of our operational units. We took cuts in many areas ... Search and Rescue, Marine Safety, Law Enforcement and VTS. All of the cuts affect safety in some manner. However, we carefully considered the impact of each candidate and chose only those with the least public safety impact. In most cases the disestablished unit had a nearby 'parent unit' that could provide a similar capability. In the case of VTS, the local Coast Guard Captain of the Port (COTP) has broad vessel traffic management authority and can still take actions to ensure safe navigation if conditions warrant.

Coast Guard COTP authority has increased significantly since the 1973 Vessel Traffic Systems Analysis of Port Needs study which was the basis for establishing the VTS program. In addition there have been several marine safety initiatives since the 1973 study. New navigation safety regulations now insure vessels have maneuvering data, updated charts and properly operating navigation equipment on board. Vessel steering and engine tests are required before entering or leaving U.S. ports; we have increased our inspections of critical navigation equipment and backup systems. Vessels carrying certain dangerous cargos must now receive permission from the Coast Guard COTP before they are allowed to enter port. When deemed necessary, vessels carrying hazardous cargoes are escorted, or a special "Safety Zone" is established to ensure other vessels stay clear. We also have bridge to bridge radiotelephone requirements, anchorage requirements, Vessel Traffic Separation Schemes, and Regulated Navigation Areas to enhance navigation safety, and COTPs have increased authority to issue orders, establish safety zones and manage vessel traffic. As a result of these changes, today's COTP is vested with considerable traffic management authority which renders the VTS a less critical component to the safety of navigation than it previously may have been.

In the Safety Board's view, the foregoing response is somewhat misleading. The Coast Guard COTP has held sweeping powers to control vessel movements in U.S. ports and waterways since the early 1950s under legislation that primarily focused on port security, as it related to the prevention of sabotage and subversive acts; however, the Coast Guard also used this authority to enhance navigation safety. The Ports and Waterways Safety Act of 1972 (the act) clarified the Coast Guard COTP's authority to control vessel movements in U.S. waters from safety and pollution prevention

perspectives. This legislation specifically provided for the establishment, operation, and maintenance of VTSs. In October 1978, the act was significantly amended by Section 2 of the Port and Tanker Safety Act of 1978, placing many equipment and operating requirements on vessels operating in U.S. waters. The "new navigation safety regulations" and the "increased authority to issue orders, establish safety zones and manage vessel traffic" to which the Commandant refers have been in effect for at least 10 years and hardly can be construed as "new." Moreover, the Safety Board disagrees that any COTP can provide "a similar capability" as a fully staffed and operational VTS system. As a case in point, at the time of this accident, the COTP in New Orleans had discontinued routine harbor patrols within the New Orleans COTP zone and did not even have the capability to maintain a current listing of which ships were at anchor at any particular time. The COTP may have had the authority to control vessel traffic, but he certainly did not have the resources with which to exercise that authority. He did not have the closed-circuit television, radar and communications network, or the trained VTS personnel that are all part of a VTS capability. Authority to act does not equate to the ability to act. The Safety Board believes that the Coast Guard discontinued the New Orleans VTS strictly as a cost-cutting measure and that this action has had an adverse impact on navigation safety in this country that cannot be satisfactorily justified. A recent study,³ which looked into the Coast Guard's closing of VTS systems, conducted by the U. S. General Accounting Office stated the following:

The VTS program consisted of seven VTSs at the beginning of fiscal year 1988. At three--Prince William Sound, Alaska; Puget Sound, Washington; and Berwick Bay, Louisiana--either statute or federal regulations require specified vessel types to contact the VTS and continuously monitor the VTS radio frequency while moving within the VTS area. The other VTSs--New York, New Orleans, San Francisco, and Houston/Galveston--are voluntary, with specified vessel types only encouraged to participate. The New Orleans and New York VTSs were decommissioned in March and July 1988, respectively.

In selecting VTSs to close, the Coast Guard primarily considered three factors:

- o VTSs with voluntary participation were chosen because they would not take as long to close as mandatory VTSs, since changes to federal laws and regulations would not be required.
- o Voluntary VTSs with the lowest reported participation rates in the fourth quarter of fiscal year 1987 were chosen. New York and New Orleans were the only two VTSs with

³"Coast Guard: Better Information Needed Before Deciding on Facility Closings", GAO/RCED-89-48, November 29, 1988.

participation rates under 99 percent, 79 and 61 percent, respectively.

- o Encountering as little local resistance as possible to closing a VTS was the third factor. The Coast Guard believed it could close the New York and New Orleans VTSs with a minimum of resistance.

We were told an additional advantage in selecting New Orleans was the avoidance of over \$16 million in planned expenditures to upgrade the equipment.

Of the factors used by the Coast Guard to determine which VTSs to close, only the second one--user participation rates--considered the success of the VTSs in achieving program goals. The others, based solely on which VTSs could be closed quickly and where capital expenditures could be saved, did not concern VTS effectiveness in enhancing vessel safety--including prevention of accidents and fatalities and protection of the environment through prevention of oil spills and accidents involving hazardous cargoes. The use of participation rates, however, disregarded the Coast Guard's plans for establishing federal regulations to require participation for New York and New Orleans, which would have given all VTSs approximately the same rate of participation.

The Coast Guard was given a Congressional mandate by the act to "establish, operate, and maintain vessel traffic services and systems for ports, harbors, and other waters subject to congested vessel traffic." Because New Orleans and New York, which are two of the busiest ports in the nation, are subject to the congested vessel traffic to which the act refers, the Safety Board believes that the VTS systems in New Orleans and New York should be reopened. Further, the Coast Guard had requested and received Congressional approval in 1985 and 1986 for \$6.41 million for needed improvements to the New Orleans VTS system--three short-range radar installations, five closed-circuit television systems, a long range radar, and a VHF communications link for the entire VTS system. The Safety Board believes that the New Orleans VTS system should be expanded as the Coast Guard had planned.

In a January 1989 letter to the Secretary of Transportation, the Safety Board requested DOT to seek funding for the Coast Guard to restore the full services of the VTSs that have been disestablished or reduced by budget constraints. Since the New Orleans and New York VTS units have been disestablished, the Board believes that Safety Recommendation M-88-39 is no longer appropriate. Accordingly, Safety Recommendation M-88-39 has been classified "Closed--Unacceptable Action/Superseded", and the superseding recommendations are included in the Board's report of the striking of a submerged object by the Bahamian Tankship ESSO PUERTO RICO.

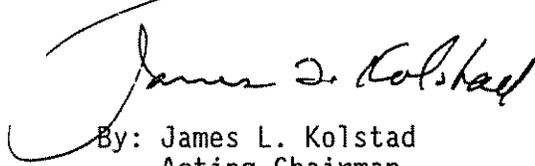
Therefore, as a result of its investigation, the National Transportation Safety Board recommends that the Department of Transportation:

Re-establish the Vessel Traffic Services in New York and New Orleans. (Class II, Priority Action) (M-89-39)

Concurrent with its re-establishment, upgrade the Vessel Traffic Service system in New Orleans as proposed by the Coast Guard in 1985. (Class II, Priority Action) (M-89-40)

Also, the Safety Board issued Safety Recommendations M-89-41 and -42 to the U.S. Coast Guard.

KOLSTAD, Acting Chairman, and BURNETT, LAUBER, NALL, and DICKINSON, Members, concurred in these recommendations.


By: James L. Kolstad
Acting Chairman